TRRx Request for Proposals Questions and Answers
April 09, 2003

Question 1. Section H.2.2 states, "Subject to paragraph H.2.5. below, the contractor will earn an incentive if the total actual network reimbursement cost in a contract option period is less than the total network reimbursement cost that would have resulted from applying the Guaranteed Average Discount Percentage and the Guaranteed Average Dispensing Fee per prescription to the prescriptions filled in the network during the contract option period. The costs will be calculated by applying the AWP that is in effect at the time the prescription transaction is processed. The cost calculations will include the impact of using the lower of the calculated price or the Usual & Customary price. The incentive will equal 5% of the difference between the actual costs and the Government calculated costs, up to the maximum amounts per contract option period listed below (table excluded)." With respect to this section, we have the following questions:

a. Please provide a precise definition of total actual network reimbursement cost in a contract option period'?

b. Please provide a precise definition of 'total network reimbursement cost that would have resulted from applying the GADP and the GADF . . "

c. Please define "Usual and Customary price."

d. Please illustrate through example how both costs mentioned in sections a and b would be determined for the following claim types: Claims involving OHI; Claims in which the plan co-pay requirement exceeds AWP plus the guaranteed dispensing fee; Claims from specialty pharmacies; Claims (generic) where the ultimate allowance is based on MAC pricing logic; Claims where the pharmacy billed charge is lower than U&C.

e. If not clear from answers to prior questions, please state how member cost sharing will be included in the determination of costs defined in questions 1 and (sic).

Response 1 a. This is the cost, determined by PDTS, the Government incurred for reimbursing network pharmacies, inclusive of pharmaceutical costs, discounts and dispensing fees.

b. This is the cost, defined in Section L.8.3.3., called, “Total Expected Government Cost for Reimbursement of Network Retail Pharmacy Costs.” The references in Section H.2.2. and H.2.3. will be revised to read as such.

c. Usual and Customary refers to normal charges applicable to the pharmacy in question.

d. 1. Claims involving OHI are not applicable to the calculation

2. Claims in which the plan co-pay requirement exceeds AWP plus the guaranteed dispensing fee equate to U&C charges. For example, the U&C calculated price for the dispensed prescription equals $7.30, the product is a brand name, not a generic, and as a result the co-pay would be the U&C charge of $7.30 and not the plan design charge of $9.00.

3. Claims from specialty pharmacies are not applicable to the calculation

4. Claims (generic) where the ultimate allowance is based on MAC pricing logic -- generic reimbursement rates are a part of the guaranteed average discount percentage and guaranteed average dispensing fee and will be

included in the calculation. Offerors should include the Generic MAC pricing in their Average Generic pricing.

5. Claims where the pharmacy billed charge is lower than U&C will be included in the calculation. For example, the U&C calculated price for the dispensed prescription equals $7.30, the product is a brand name, not a generic, and as a result the co-pay would be the U&C charge of $7.30 and not the plan design charge of $9.00.

e. The incentive calculation will be completed based on the offeror's proposed and realized discount rates and dispensing fees. Member cost sharing is not a part of this calculation.

Question 2. Section H.2.3 states, "The Government will assess a Negative Incentive if the total actual network reimbursement cost in a contract option period exceeds the total network reimbursement cost that would have resulted from applying the Guaranteed Average Discount Percentage and the Guaranteed Average Dispensing Fee per prescription to the prescriptions filled in the network during the contract option period. The difference between actual costs and Government calculated costs will be deducted from future payments to the contractor." With respect to this section, we have the following questions: (a) Please explain the rationale for holding contractors responsible for 100% of cost over-runs, but offering only a (capped) 5% incentive payment for cost savings. (b) Given the disparity between positive and negative incentive percentages, will the Government consider a loss/gain carry-forward provision based on 100% of differences between actual and Government calculated costs. (c) With respect to Section C.8.2., please confirm that these claims will not be counted for purposes of determining financial incentives described in Section H.2.

Response 2. (a) The RFP holds offerors responsible for their proposed network agreements and network reimbursement rates while simultaneously providing incentive payments for cost savings achieved when more favorable reimbursement rates are established.

(b) No. The Government is confident that offerors have the expertise to determine guaranteed reimbursement rates that are competitive and achievable.

(c) Noncompliant claims will not be included in the incentive calculation.

Question 3. Page 59, section L.9.6 , last sentence states: "Offerors shall also submit references from the five largest PBM related customers for each of it partner or consortium members in accordance with paragraph L.15.3." It appears that it should reference paragraph L.9.2. - is this assumption correct? Section L ends at L.13. Then there are attachments L-16 thru L-19.

Response 3. You are correct. The correct reference is L.9.2.

Question 4. Is the government also seeking a material management system through this RFP? If not, is there a material management system currently in use that the vendor has to interface with?

Response 4. The Government is not seeking a material management system, nor is there a requirement to interface with such a system.

Question 5. Reference RFP Section C.14 Information Technology, page 9: This citation and sub-points of C.14 discuss the IT requirements. We do not see any instructions in section L or M as to where the Government desires the IT to be addressed. Does the Government desire the IT requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 5. The successful offeror must comply with the requirements of C.14. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 6. Reference RFP Section C.15 Marketing and Education, page 11: This citation and sub-points of C.15 discuss the Marketing and Education requirements. We do not see any instructions in section L or M as to where the Government desires the Marketing and Education to be addressed. Does the Government desire the Marketing and Education requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 6. The successful offeror must comply with the requirements of C.15. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 7. Reference RFP Section C.16.3 Title Missing, page 12: This citation and sub-points of C.16.3.2 and C.16.3.4 discuss the Fraud and Abuse Detection Plan, and the Appeals Plan. We do not see any instructions in section L or M as to where the Government desires these sections to be addressed. Does the Government desire RFP C.16.3.2 and C.16.3.4 requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 7. The successful offeror must comply with the requirements of C.16.3.2. and C.16.3.4. However, these sections are not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 8. Reference RFP Section C.16.4 Title Missing, page 12: This citation at C.16.4 discusses the Training Plan. We do not see any instructions in section L or M as to where the Government desires these sections to be addressed. Does the Government desire RFP C.16.4 requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 8. The successful offeror must comply with the requirements of C.16.4. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 9. Reference RFP Section C.17 Legal Matters, page 12: This citation at C.17 discusses Legal Matters. We do not see any instructions in section L or M as to where the Government desires this section to be addressed. Does the Government desire RFP C.17 requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 9. The successful offeror must comply with the requirements of C.17. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 10. Reference RFP Section C.18 Records Management, page 12: This citation at C.18 discusses the Records Management requirements. We do not see any instructions in section L or M as to where the Government desires this section to be addressed. Does the Government desire RFP C.18 requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 10. The successful offeror must comply with the requirements of C.18. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 11. Reference RFP Section C.19.6 Website, page 13: This citation at C.19.6 discusses the Website requirements. We do not see any instructions in section L or M as to where the Government desires this section to be addressed. Does the Government desire RFP C.19.6 requirements to be addressed in the Technical written proposal or in the Technical oral presentation?

Response 11. The successful offeror must comply with the requirements of C.19.6. However, this section is not a part of the proposal evaluation and shall not be addressed in offeror proposals.

Question 12. Reference RFP Section C.20 Contract Phase-In: The RFP requirements for Contract Phase-In appear to be very high level. Is the Offeror to reference the TRICARE Operational manual for details regarding Contract Phase-In? For example, does TMA expect the Contract Phase-In approach to convert pharmacy paid claims historical files? If yes, can the Government provided any information about these files and expected conversion plans?

Response 12. No, the offeror is not to reference the TOM for details regarding Contract Phase-in. The contractor will not be required to convert pharmacy paid claims historical files.

Question 13. Reference RFP Section C.20 Contract Phase-In: This RFP citation describes a Contract Phase-In that begins at contract award and is to be completed within 180 calendar days. Considering the fact that the current MCSC, including pharmacy processing, terminates by contract region and spans from April 2004 to November 2004, we would have expected to see a TRRx phase-in over this eight-month period. (a) Will the Government please explain why the TRRx is planned for a single national implementation after the 180-day period? (b) Will the Government be modifying the current MCSC contracts to terminate the pharmacy benefit all effective 180 days after TRRx contract award? (c) Has the Government evaluated the risks associated with a single national implementation? (d) If a risk assessment has been made, can a copy of the assessment be made available? (e) Would the Government reconsider the Contract Phase-In approach and allow the TRRx contractor to phase-in the pharmacy benefit by terminated MCSC region?

Response 13. (a) A single nationwide implementation is more efficient and better serves our beneficiaries.

(b) The Government anticipates Termination for Convenience proceedings at the appropriate time to terminate retail pharmacy services from the existing Managed Care Support contracts.

(c) The pros and cons of a single national implementation were assessed by TMA/HA management.

(d) A decision paper was presented to TMA/HA leadership identifying the pros/cons of our current strategy. The document will be made available under the Freedom of Information Act upon request.

(e) No.

Question 14. Reference RFP Section M.3.3.4 page 64: The RFP has duplicate M.3.3.4 outline numbers.

Response 14. Thank you, you are correct. The second reference should read: M.3.4. Factor 4: PBM Operations.

Question 15. Reference RFP Attachment Zip Code File: This access data base file provides beneficiary counts by zip code with a breakdown by Beneficiary Category Values. RFP Section C.7 describes the access standards for a three area designation: Urban, Suburban, and Rural. Can the Government provide a file of zip codes designated by Urban, Suburban, and Rural, or provide its policy for which zip codes are to be considered for each of the three zip code designations?

Response 15. Definitions for the Urban, Suburban and Rural categories are derived from the Department of Labor, Bureau of Labor Statistics and may be found at Section J, Attachment 2, Definitions.

Question 16. Reference RFP Section L.8.4.1 Sub-factor 1 – Claims Processing, page 56: Last sentence of this section states, "The offeror shall describe its plan to integrate DoD's retail pharmacy business, including its current capacity and its plan to add capacity, if necessary, during the phase-in period or through the life of the contract." (a) This citation, we assume, deals with operational claims processing capacity, is this correct? (b) Assuming this is correct, can the Government describe TRRx events, other than the claims growth as provided in Section B, that may have an impact on capacity needs during the phase-in period or during options years of the contract?

Response 16. (a) Yes.

(b) Section B provides the Government's best estimate of volume growth. This may, of course, be impacted by future changes to the force structure affecting eligibility, e.g., the current Reserve call-up in support of Iraqi Freedom.

Question 17. Reference RFP Section, C.19, C.19.5, C.16.3.4, C.8.5, C.9, C.4.1: Throughout the referenced sections above, the RFP requires the offeror to discuss and present solutions to a specific process and sets of requirements. Further, the offeror must use its solution to develop an appropriate pricing structure that can be supported through the evaluation's reasonableness tests. In order to ensure solutions are sound and pricing is accurate, offerors are in need of historical retail pharmacy volume data or at a minimum, workload assumptions in the following areas: (a) Toll Free Beneficiary (member) Telephone Calls; (b) Toll Free Provider Calls; (c) Appeals; (d) Written inquiries; (e) Denied prescriptions; (f) Other Health Insurance cases and Usage of DD 2642 claim forms; (g) Initial TRICARE Pharmacy Information Card mailing and annual card usage.

Response 17. (a) This information is not available to the Government. Recommend offerors utilize comparable data from their commercial book of business.

(b) This information is not available to the Government. Recommend offerors utilize comparable data from their commercial book of business.

(c) This information is not available to the Government. Recommend offerors utilize comparable data from their commercial book of business.

(d) This information is not available to the Government. Recommend offerors utilize comparable data from their commercial book of business, .

(e) This information is not available to the Government. Recommend offerors utilize comparable data from their commercial book of business.

(f) Data over the last 16 months indicates that 97% of retail pharmacy claims are submitted electronically. The remaining 3%, inclusive of OHI, are submitted via paper claim form.

(g) The contractor is required to distribute the Information Card to beneficiaries who have used retail pharmacy services within the 12 months preceding the mailing. Approximately 2.5 million beneficiaries are active users of retail pharmacy services. On a monthly basis, there are approximately 50,000 newly eligible members. However, this number may be 2-3 times higher during periods of substantial Reserve call up as we are experiencing in support of Iraqi Freedom. The contractor will also need to have sufficient quantities of brochures and Information Cards available to support the total 8.7 million beneficiary population.

Question 18. Reference RFP Section M.6.4.5 Sub-factor 5 Beneficiary (Member) Services, page 67: The last sentence in this citation states, "The Government will also evaluate any additional performance standards the offeror proposes to meet or exceed.["] Is this additional evaluation limited to Beneficiary (Member) Services? Will the Government evaluate additional performance standards if proposed for functions in addition to Beneficiary Services? Please explain.

Response 18. This applies only to Factor 4, Subfactor 4, Beneficiary (Member) Services. The Government has specified a few minimum standards with which the successful offeror must comply. The Government has provided an opportunity for the offeror to proposed additional

standards that may result in a higher evaluated rating for Factor 4. The evaluation of this factor and all other factors will be conducted as specified in Section M.

Question 19. There does not seem to be a requirement defined for the TRRx to receive files in HCSR format from current MCS contractors which would allow them to ensure duplicate claims are not paid between the new contract and old contracts. Is this an omission TMA will amend in the RFP or is the intent not to include file transition from current contractors?

Response 19. The Government does not foresee a need to transfer files from the outgoing contractors. Drug Utilization Review will be performed by the Government's Pharmacy Data Transaction Service.

Question 20. In C.20.1 regarding phase in of this contract, the RFP says the contractor must be prepared to begin contract performance no later than 180 calendar days after contract award. Is it the government's intent for the TRRx contractor to assume responsibility for claim processing nationally without regard for the transition schedule established between the old MCS contracts which include pharmacy claim processing and the new MCS and TDEFIC contracts that do not include pharmacy services? Will the government amend this RFP to require multiple start ups between 4/1/04 and 11/1/04?

Response 20. The successful offeror shall begin contract performance nationally 180 days after contract award. The Managed Care Support contractors will remain responsible for claims associated with pharmacy services rendered prior to start of performance by the TRRx contractor.

Question 21. (a)Will Biotech meds be broken out on proposal? (b) Will awarding of the contract be regionalized or given to one vendor?

Response 21. (a) No. (b) A single award will be made to one contractor.

Question 22. There is a discrepancy in the oral presentation described in Section L and the Evaluation Factors in Section M. Page 57, L.8.5.6.2. States - "Only Evaluation Factor 3 and its subfactors listed above shall be discussed in the oral presentation. The offeror shall not describe its approach or processes for meeting any other requirements." Factor 3 is PBM Services, (Claims Processing, QA Plan, Disaster Recovery, Phase-in Plan). However, on Page 64, under M 3.3.4, Factor 4, sub 1, sub 2, sub 3, sub 4 and sub 5, it states, "evaluation based on oral presentation." Factor 4 is PBM Operations, (Pharm Help Desk, Prior Auths, Medical Necessity Determinations, Management, Bene Services). Also on page 64, its says that for Factor 3, "evaluation will be based on written proposal." Please clarify.

Response 22. Thank you. You are correct. Section L.8.5.6.2. should state that only Evaluation Factor 4, PBM Operations shall be covered in the Oral Presentation. This will be corrected.

Question 23. RFP Sections L.7, L.8.5.6.2, M.3 appear to be in conflict. L.7 & M.3 indicate that Factor 4 and its subfactors will comprise the Oral Presentation. However, L.8.5.6.2 says "Only

Evaluation Factor 3 and its subfactors listed above shall be discussed in the oral presentation." Please clarify whether Factor 3 or 4 is to be the content of the Oral Presentation.

Response 23. Thank you. You are correct. Section L.8.5.6.2. should state that only Evaluation Factor 4, PBM Operations shall be covered in the Oral Presentation. This will be corrected.

Question 24. H.2.1.; states "The following table, Network Reimbursement Table H-1, contains the "Guaranteed Average Discount Percentage" and "Guaranteed Average Dispensing Fee" proposed by the contractor by Brand and Generic drugs for each respective option period." Please confirm that this table includes only electronic retail network pharmacy claims and excludes paper claims. If this is not the case, please provide clarification regarding the expectations for completing Table H-1.

Response 24. Table H-1 includes all network electronic claims. The financial incentive calculations based on Table H-1 do not include paper claims, nonnetwork claims, claims for compounded drugs, or claims with OHI. Following award, this table will be completed by the Government based on the successful offeror's guaranteed reimbursement rates.

Question 25. Section H.4.3.; states "The contractor agrees to report to the Government any security incident of which it becomes aware." Please confirm that this requirement only relates to Government-specific PHI. Does the Government keep this information confidential?

Response 25. This requirement relates to any security incident that could ultimately have an impact on the Government. The Government keeps all documentation confidential subject to the Freedom of Information Act.

Question 26. Section H.4.5.; states "The contractor agrees to make internal practices, books, and records relating to the security of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Government, available to the Government, or at the request of the Government to the Secretary, in a time and manner designated by the Government or the Secretary, for purposes of the Secretary determining the Government's compliance with the Security Rule." Confirm that "books" refers to written documentation. Confirm that the information that is to be made available to the Government is information that is specific to the TRRx contract. If not, please clarify. Would the Government consider modifying "in a time and manner" to "in a reasonable time and manner"?

Response 26. "Books" refers to any written, printed, typed, copied, scanned or electronic data maintained by the contractor.

Question 27. L.3.; states "52.211-14 NOTICE OF PRIORITY RATING FOR NATIONAL DEFENSE USE (SEP 1990) 11.604). Confirm that this contract is priority rated. If so, will it be designated DX or DO?

Response 27. The contract will be DO rated.

Question 28. What is the deadline for contractors to submit questions or request clarifications?

Response 28. Questions will be accepted through 1700 MDT, April 14, 2003.

Question 29. Will contractors be allowed to submit questions or request clarifications after the pre-proposal conference?

Response 29. Questions will be accepted through 1700 MDT, April 14, 2003.

Question 30. When will the Government provide written answers to the questions or request clarifications submitted by contractors?

Response 30. The Government will answer questions as quickly as possible, and they will be posted on the Retail Solicitation Web Site. Once a question is submitted, and depending upon the number of questions received, the Government will attempt to answer and post the question within 10 days of receipt.

Question 31. C.4.1.; states "The contractor shall provide each beneficiary with a wallet sized TRICARE Pharmacy Information Card providing the instructions and the information necessary for a retail pharmacy to submit a claim to the TRRx contractor. The information card shall contain a summary of the TRRx program and the contractor's contact information, consistent with the guidance provided by National Council for Prescription Drug Programs (NCPDP) in its Implementation Guide, Health Care Identification Card, Pharmacy ID Card, Version 1, Release 7, published October, 2002. The card shall not contain any beneficiary specific information. The TRRx program information shall be on one side, and information provided by the Government on the TRICARE Mail Order Pharmacy shall be placed on the reverse side. This information card is for informational purposes only and does not grant TRICARE eligibility." Please provide samples of the information required on both sides. Please confirm the wallet sized TRICARE Pharmacy Information Cards are for informational purposes only. It is our understanding the TRICARE Pharmacy Information Card will not have beneficiary names, beneficiary ID number, group numbers, bin numbers, etc…normally found in the commercial setting. Are we correct in our understanding?

Response 31. Your assumptions are correct. The card shall not contain any beneficiary specific information. It should include the information specified in C.4.1. This information would include information necessary to facilitate electronic submittal by the pharmacy. An upcoming amendment will add a requirement for an address and telephone number where the beneficiary may contact the contractor for additional information or appeal denial.

Question 32. C.4.2.; states "The card shall be made of a durable, wrinkle resistant material. Quarterly, the contractor shall mail this information card to new eligible beneficiaries within 30 calendar days of receiving a list of new eligible beneficiaries from the Government. Throughout a11 option periods, supplies of TRICARE Pharmacy Information Cards shall also be furnished to TRICARE Service Centers (TSC) and Military Treatment Facilities (MTF) as part of the marketing effort in cooperation with TRICARE Management Activity (TMA) Communication and Customer Service Directorate (C&CS)." Will the card be multi-colored; have logo

requirements, etc.? Please provide additional information regarding the DOD's expectations on design, quantities, and frequency (both initial and ongoing) of distribution to TSCs and MTFs.

Response 32. The card shall be marked to identify the TRICARE benefit and may include the TRICARE logo. The contractor may design the card in accordance with its normal commercial practice. The card shall be included in the contractor's initial marketing mailing to beneficiaries who have used retail pharmacy services in the 12 months preceding the start of pharmaceutical delivery under this contract. Currently, there are approximately 2.5 million active users of retail pharmacy services. There are approximately 50,000 new beneficiaries each month. The contractor shall ensure sufficient quantities are available to support all 8.7 million eligible beneficiaries.

Question 33. C.5.2.; states "All network pharmacies shall be fully licensed and certified in accordance with applicable Federal and State laws, credentialed according to the contractor's criteria, and have a National Council for Prescription Drug Programs (NCPDP) number. Pharmacies providing pharmaceuticals solely through Internet or mail order pharmacies shall not be included in the TRRx network. Specialty pharmacy services may be provided through the mail. Retail pharmacies who offer to mail prescriptions to beneficiaries as part of their business may be included in the network, subject defined by the TRICARE benefit." Please describe how retail pharmacies who offer to mail prescriptions to beneficiaries as part of their business differs from the TMOP? What effect or impact will retail pharmacies who offer to mail prescriptions to beneficiaries as part of their business have on the TMOP contract? Please elaborate.

Response 33. Retail pharmacies that mail prescriptions to beneficiaries are subject to the quantity limits established for retail pharmacies, i.e., one co-pay for each 30 day prescription as opposed to the TMOP standard of one co-pay for each 90 day prescription. The Government cannot predict what impact, if any, this will have on the TMOP.

Question 34. C.6.2.; states "All pharmacies shall maintain a process to document receipt of the medication by the beneficiary or the beneficiary's authorized agent." We note that Attachment 13, Records Management, requires contractors to "institute measures to ensure records of continuing value are preserved and appropriate disposition is made of records no longer of current use." Does the Government expect that the contractor will be required to monitor each pharmacy's records management system to ensure that adequate records are being maintained in accordance with the DOD Records Management policy? Please clarify the Government's expectation.

Response 34. No. Attachment 13 refers to records maintained by the contractor. The contractor is responsible for ensuring that network pharmacies maintain records in accordance with Federal and State law, and the requirements of this contract.

Question 35. C.8.1.; states "The contractor shall accept and process all claims received from network and non-network pharmacies, and from beneficiaries for pharmaceuticals and supplies furnished in the 50 United States, the District of Columbia, Guam, the U.S. Virgin Islands and Puerto Rico. Pharmaceutical claims received for pharmaceuticals and supplies furnished in other locations shall be forwarded to the TRICARE contractor responsible for processing claims for

those locations. The contractor shall ensure that each claim passes administrative claim processing edits as defined in the TRRx PDTS Interface Control Document (ICD) at Attachment 4, Section J. The contractor shall use the data provided by Defense Enrollment Eligibility Reporting System (DEERS) through PDTS to calculate beneficiary co-pay amounts and to determine the appropriate bank account from which to pay pharmacy claims, i.e., the Department of Defense Medicare Eligible Retiree Health Care bank account or the TRICARE bank account. The data from DEERS to calculate the co-pay amounts shall be provided to the contractor at the time filling the prescription is authorized. The demographic data from DEERS necessary to determine the appropriate bank account will be provided to the contractor two calendar days before PDTS submits the TRICARE Encounter Data (TED) record to TMA. The contractor shall match the DEERS data to the claim records, and provide the account data back to PDTS to be included in the TED record within one calendar day of receipt of the demographic data. Please provide information regarding what types of non-network pharmacies (e.g., VA Hospitals) are allowed to submit paper claims under the TRRx program. What is the historical and expected volume of paper claims from non-network and network claims for this program?

Response 35. Paper claims are normally submitted by beneficiaries when they fill prescriptions at non-network pharmacies. Beneficiaries may use any licensed pharmacy. Currently, paper claims comprise approximately 3% of total pharmacy claim volume. This includes use of non-network pharmacies and cases where OHI is present. VA does not bill TRICARE for dual eligible beneficiaries (TRICARE/VA dual eligible) receiving care from VA facilities. Although this is subject to change, we do not foresee the VA submitting paper claims.

Question 36. C.8.3.; states "The contractor shall implement a recoupment program in accordance with Attachment 3, Section J to recoup erroneously paid Government funds. Prescriptions subject to recoupment may be identified by the Government, or by the contractor through its audit procedures." Will contractors be allowed to retain a portion of the recoupment to off-set operational costs?

Response 36. No. Operational costs of collecting recoupments should be included in the proposed administrative fee.

Question 37. C.8.4.; states "In addition to Government data requirements specified herein, in Section F, and in Section J, the contractor shall provide the Government read-only access to its claims system to facilitate Government beneficiary service support. Access will be provided beginning not later than the start of Option 1 and continue to contract completion." Will contractors be required to provide the Government the terminals and hardware necessary for read only access? How many Government individuals will need the read only access? Where will they be located?

Response 37. The Government will provide its own hardware. Government personnel may be located at the PDTS Customer Service Center in San Antonio, Texas and at TMA in Aurora, Colorado. The Government will require access for 6-15 individuals, covering both sites.

Question 38. C.8.5.; states "For denied prescriptions, the contractor shall provide the pharmacy with the reason for the denial and an address and telephone number where the beneficiary may

contact the contractor for additional information or appeal the denial in accordance with the requirements at C.16.3.4. "Appeals Plan"." The Department of Labor (DOL) has determined that a denial at the point of sale does not constitute an "adverse benefit determination." Thus, DOL determined that no written denial or other notice of rights of appeal are required at the point of sale. A standard practice is for PBMs to communicate denials to pharmacy providers at the point of sale electronically using NCPDP denial codes. The contact information for beneficiaries to appeal a decision is typically provided on the ID card. Will the Government consider modifying this requirement such that the requirement for providing the address and phone number for appeal are provided on the beneficiary ID card instead of provided by the pharmacist at the point of sale?

Response 38. Thank you, that is a good suggestion. We will include that change in an upcoming amendment.

Question 39. C.8.7.; states "The contractor shall ensure the availability of DD 2642 claim forms to be used by beneficiaries. The contractor shall coordinate with the Managed Care Support Contractors (MCSC) to ensure the availability of the DD 2642 claim form at the TRICARE Service Centers. The contractor shall also make the form available for downloading from its TRRx web site. Paper claims for non-network pharmacy services shall be reimbursed at billed charges minus co-pay and applicable deductible. The contractor shall receive paper claims from beneficiaries who use non-network pharmacies, or from beneficiaries submitting OHI claim balances, i.e. split-billing. Paper claims for OHI claim balances shall be processed to reimburse the beneficiary's personal liability of the balance remaining after the OHI has paid, up to the amount that would have been covered by TRICARE in the absence of OHI. The contractor shall enter these claims into its claims payment system for processing and submittal of required data to PDTS. The contractor shall be held to the same standards for data quality specified in the PDTS ICD as established for electronic claims." The DD-2642 claim form on the website (http://www.dior.whs.mil/forms/DD2642.PDF) states that the form was obsolete as of 9/30/02. Has the form been updated and, if so, will the Government provide an updated version? Will the DOD provide the DD-2642 in an electronic format to contractors to make available for downloading from our TRRx web site? Will the DOD consider online availability of the claim form (so the Service Centers can print out their own copies) an acceptable option to the requirement of ensuring "availability…at the TRICARE Service Centers"? If contractors are expected to print or create the DD 2642 claim forms, please provide the anticipated quantities and frequency.

Response 39. The form may continue to be used until updated. An updated form is currently being developed and will be available at contract award. The form will be maintained on the TMA web site and the contractor may include a link to that site on its web site. Beneficiaries will be able to complete the form on line prior to printing the form for submittal to the contractor. The contractor will not be required to supply the form to the TRICARE Service Centers. The contractor shall mail the form to beneficiaries upon request. This will be clarified in an upcoming amendment.

Question 40. C.8.8.; states "TRRx Claims Processing Standards; state "C.8.8.1. 99% of electronic claims shall be processed to completion within five seconds of receipt, measured on a

monthly basis. This processing time is exclusive of the time the transaction is being processed at PDTS; C.8.8.2. 100% of electronic claims shall be processed to completion within five working days of receipt, measured on a monthly basis; C.8.8.3. 95% of paper claims shall be processed to completion within ten working days of receipt, measured on a monthly basis; C.8.8.4. 100% of paper claims shall be processed to completion within 20 working days of receipt, measured on a monthly basis" Please confirm the term "processed to completion" is limited to the time the claim is in the contractor's system and does not include transmission times to and from PDTS.

Response 40. Confirmed.

Question 41. C.10.; states "Databases. The contractor shall ensure that all contractor reference database files are maintained and updated within five business days of the most recently published update. Those files include but are not limited to DEA provider files, Medispan, First Data Bank, Micromedex, HCIdea, and National Council for Prescription Drug Program (NCPDP) provider file. These database files are not subject to Privacy Act records keeping and management requirements. Please confirm that the last sentence means that these database files are not subject to the Records Management policy (Attachment 13)?

Response 41. Confirmed.

Question 42. C.11.; states "Prior Authorizations; states "The Government may, through the DoD Pharmacy and Therapeutics (P&T) Committee, designate certain drugs that require Prior Authorization prior to being dispensed. The Government will provide its own criteria or ask the contractor to propose Prior Authorization criteria for review, modification and adoption by the Government. All Prior Authorization criteria are subject to DoD P&T Committee approval. The contractor shall not deny any claim without first submitting to PDTS to determine whether a previously approved authorization is on file. The contractor shall accept prescriber-completed Prior Authorization request forms from beneficiaries, physicians and pharmacies by electronic or hardcopy media. Telephonic Prior Authorization reviews shall only be completed with prescribers. The contractor shall review the requests and approve or deny them in accordance with Government-approved Prior Authorization criteria. The contractor shall submit all Prior Authorization approvals and denials into PDTS as described in the TRRx PDTS Interface Control Document (ICD) at Attachment 4, Section J. The contractor shall complete reconsiderations of initial determinations and complete appeals in accordance with the requirements at C.16.3.4 "Appeals Plan"." Please provide the Government's list of all drugs currently being Prior Authorized and their respective Government criteria. What is current annual number of Prior Authorizations?

Response 42. The listing of drugs for which the Government requires prior authorization, and their criteria, can be viewed at www.pec.ha.osd.mil. The current Managed Care Support contractors may require prior authorization for additional drugs. The Government does not know the current number of prior authorizations performed by the Managed Care Support Contractors. The projected volume of prior authorizations is listed in Section B of the RFP.

Question 43. C.12.; states "Medical Necessity Determinations

C.12.1. Upon request by the beneficiary, the contractor shall use Government provided criteria to determine whether Medical Necessity substantiates the need to provide the beneficiary a non-formulary drug at the formulary co-pay. The contractor shall accept prescriber-completed information from beneficiaries, physicians and pharmacies by electronic or hardcopy media. Telephonic information shall only be accepted from prescribers. Medical Necessity determinations shall be completed by physicians, pharmacists, registered nurses, or physician assistants.
C.12.2. The contractor shall submit all Medical Necessity Determination approvals and denials into PDTS as described in the PDTS ICD at Attachment 4, Section J. The contractor shall complete reconsiderations of initial determinations and "Appeals Plan" below."

Please confirm that it is the Government's intent that the physician makes the final determination of Medical Necessity and, as such, the Government is not requiring the contractor to determine Medical Necessity.

Response 43. No. The contractor shall be responsible for making Medical Necessity determinations based on Government provided criteria in accordance with Section C.12.

Question 44. C.15.2.; states "The contractor shall complete a Memorandum of Understanding (MOU) with the TMA C&CS for future marketing and educational materials requirements (subsequent to the initial mailing described at C.20.2) and the submission of pharmacy updates to be included in TRICARE educational materials." What are the current marketing and educational materials requirements? What does the Government expect for the "future marketing and educational materials requirements?" Will the Government provide a sample MOU?

Response 44. Current marketing and educational requirements are specified in the RFP at Section C.15 and C.20.2. Under this contract, following the initial mailing to current users, the Government anticipates educational news articles developed by the TRRx contractor to be included in the quarterly newsletters published by the Managed Care Support contractors. There are no existing MOU's to use as an example.

Question 45. C.16.2.; states "The contractor shall support ongoing management interaction between the Government and the contractor. The contractor shall identify points of contact for contractual and business issues, administrative support including pharmacy issues and information technology issues. Clinical support shall be provided by the contractor to support the Government in the Pharmacy and Therapeutic Committee process, utilization management initiatives, benefit design and utilization review. The DoD P&T committee meets on a quarterly basis for approximately three days. The contractor shall have a process in place to support the implementation of TRICARE (client) specific operating procedures throughout the life of the contract." (a) Please provide detailed insight to the Government's expectations in regards to "ongoing management interaction between the Government and the contractor". Will this include time and travel away from a contractor's place of business? (b) Please provide detailed insight to the Government's expectations in regards to clinical support of the Government's Pharmacy and Therapeutic Committee process, utilization management initiatives, benefit design and utilization review? Will this include time and travel away from a contractor's place of

business? (c) Will the Government require "100% dedicated" personnel? Meaning the Government will be their only client.

Response 45. (a) The Government's expectation is for the Government and the successful offeror to enter into a business partnership, whereby, the exchange of information and data between the two is on-going. It will be necessary for the successful offeror to travel away from its place of business in support of the requirements of this solicitation. An example of such travel would be for supporting security and marketing efforts, as well as potential recurring management reviews.

(b) The Government anticipates the contractor will provide a representative to the P&T Committee meetings. These meetings are held on a quarterly basis in San Antonio, Texas or Washington, DC. We project that the meetings will each last three days.

(c) The Government does not require that management personnel be dedicated 100% to the management of this contract. However, given the size of the program, the Government would anticipate that it would receive direct access to management personnel and rapid turnaround of issues identified.

Question 46. C.17.; states "The contractor shall provide immediate telephonic notice, followed by written notice to the TMA Office of General Counsel within three calendar days, of receipt of any civil or criminal complaints or subpoenas filed against it in any judicial or administrative tribunal pertaining to services under this contract. For informational purposes only, the contractor shall provide written notice to the Contracting Officer of any civil or criminal complaints or subpoenas filed against any network pharmacy within seven days of when the information first becomes known to the contractor." Pharmacies are independent contractors and, as such, we do not require them to provide us with written notice of any civil or criminal complaints or subpoenas filed against them. Would the Government consider limiting this requirement to the contractor?

Response 46. No. As stated, this information is to be provided for informational purposes only, and only after the contractor learns of the issue(s).

Question 47. C.18.; states "Records Management. All contractor records generated under this contract, as specified in Attachment 13, Section J, shall be maintained in accordance with 36 CFR 1222.48 and Attachment 13, Section J, entitled "Records Management." The contractor shall identify its Records Manager to the Contracting Officer within ten calendar days of award. Following contract award, the contractor shall schedule its Records Manager to attend the next available TMA records management class presented annually in Denver, Colorado. The Records Manager will be required to attend the course annually thereafter. This is a five-day course." Are there any costs in addition to travel (air, hotel, car, meals, etc…) associated with this annual training?

Response 47. No.

Question 48. C.19.1.; states "The contractor shall provide TRICARE beneficiaries with toll free telephone numbers to call for assistance throughout the 50 United States, the District of

Columbia, Guam, Puerto Rico and the U.S. Virgin Islands. Where the contractor cannot resolve a specific issue which does not relate to a functional requirement under this contract it will identify and transfer the caller to other beneficiary (member) services or Government offices as required, including, but not limited to the TRICARE Mail Order Pharmacy, Managed Care Support Contractor(s), TRICARE Service Centers, Military Treatment Facilities Health Benefits Office, or the PDTS Customer Service Center. The contractor's representative shall remain on the line until the call is properly transferred to the appropriate representative. Beneficiary (member) service centers shall be staffed to meet or exceed contract requirements stated below. At a minimum, the beneficiary (member) service center shall operate from 0700 ET to 2400 ET Monday through Friday. The center shall operate, at a minimum, from 0900 to 2100 ET on weekends and holidays." Please provide the current and anticipated volume of beneficiary calls in Option 1 through 5 of this contract.

Response 48. The Government does not have any data regarding the volume of beneficiary calls relating to retail pharmacy services.

Question 49. C.19.2.; states "The contractor may use an Automated Response Unit (ARU) to receive beneficiary calls. The contractor shall provide beneficiary service to non-English speaking and hearing impaired beneficiaries. If calls are received by an ARU, 100% of all telephone calls shall be acknowledged within 20 seconds and the caller shall have only two menu choices, 1) transfer to an ARU, or 2) transferred to an individual." We are uncertain what is desired in regards to "the caller shall have only two menu choices, 1) transfer to an ARU, or 2) transferred to an individual." Please elaborate on the Government's expectations. What if contract requirements, benefit designs, etc…dictate more than two ARU choices?

Response 49. When the ARU picks up the call, the first choice on the menu tree will direct the caller to a beneficiary service representative. The intent is to get the caller to a customer service representative as quickly as possible without making the caller listen to a long list of options. This will be clarified via amendment to the solicitation.

Question 50. E.2.1., states "Upon completion of pharmaceutical dispensing services for each option, the contractor shall submit a DD Form 250, Material Inspection and Receiving Report, to the Contracting Officer's Representative for acceptance of services. This acceptance of services applies to, if exercised, option CLINs 1001, 1002, 1003, 1004, 1005, 2001, 2002, 2003, 2004, 2005, 3001, 3002, 3003, 3004, 3005, 4001, 4002, 4003, 4004, 4005, 5001, 5002, 5003, 5004, and 5005. The DD 250 constitutes provisional acceptance and does not limit the Government's rights to audit the contractor's records and recover erroneously paid funds." Is the submittal requirement for one DD250 at the end of each option performance period or are multiple submittals contemplated?

Response 50. Only one DD250 is required at the end of each option period to signify acceptance of all claims processed in the option period. Monthly DD250's may be submitted for Prior Authorizations, Medical Necessity Determinations and Information security.

Question 51. F.2.3. et seq.; states "Network Access Report (Ref Section C.7.) – A monthly report generated on the 15th calendar day of the month. It shall be submitted to the Government by the 20th calendar day of each month. The report shall use GeoAccess or similar software. The report shall include:

F.2.3.1. The total number of beneficiaries in urban areas and the number that live within 2 miles of a TRRx network pharmacy.
F.2.3.2. The total number of beneficiaries in suburban areas and the number that live within 5 miles of a TRRx network pharmacy.
F.2.3.3. The total number of beneficiaries in rural areas and the number that live within 15 miles of a TRRx network pharmacy.

Is the monthly report to reflect the number of beneficiaries who actually used a network pharmacy for the given month by urban, suburban, and rural subgroups?

Response 51. No. The report shall be based on the total number of eligible beneficiaries in each group. The Government will provide a monthly zip code file listing all eligible beneficiaries.

Question 52. F.2.8.; states "Marketing Materials (Ref section C.20.2.) - All marketing materials developed for the initial mailing to beneficiaries shall be delivered to the Contracting Officer for review 60 calendar days prior to printing. The Government will provide approval/disapproval notices within 30 calendar days of receipt. The initial mailing shall be distributed to beneficiaries 30 to 40 days prior to the start of pharmacy services." Please provide detailed insight to the Government's expectations in regards to "Marketing Materials" design, quantities, and frequency of distribution to beneficiaries. Will the Marketing Materials be multi-colored; have logo requirements, etc…? Are samples available?

Response 52. The Government does not have specific expectations relative to the marketing materials. The contractor may design these materials for maximum effectiveness in communicating the message. The Government will review to ensure proper tone, accuracy and consistency with the TRICARE benefit. The initial mailing is projected to be approximately 2.5 million units in accordance with Section L.6. Marketing updates thereafter shall be in accordance with Section C.15.

Question 53. G.1.1.5.3.; states "The contractor shall require the bank to transmit directly to TMA (no less than monthly) a listing of all payments clearing the account. The listing shall include the check/trace number and the dollar amount. This shall also be in an electronic format. (Ref Section F.2.15.)" Does the Government have a list of banks familiar with your format and willing to meet this requirement?

Response 53. No. This is a routine action for banks. TMA is not requiring a specific format for the data other than electronic submittal.

Question 54. G.6.; states "The Government and the contractor shall meet at least quarterly to discuss management and operational issues as specified in the contract Surveillance Plan at Attachment 15, section J." Will contractors be required to meet more frequently than quarterly? Where will these meetings take place? If at the contractors place of business will contractors be required to pay for the Government's travel expenses? If so, how many Government representatives will attend these meetings?

Response 54. During transition and in the beginning of the program, it may be necessary for weekly, monthly or quarterly meetings depending upon the issues that arise. The meetings may be held at the contractor's facilities or they may be held at Government facilities as required. The Government will pay its own travel costs. The number of Government representatives will range from seven to twelve personnel.

Question 55. L.8.3.3.; states "Network Reimbursement Table L-1: Table L-1 (below) identifies the offeror's Guaranteed Average Discount Percentage and the offeror's Guaranteed Average Dispensing Fee Per Prescription. The figures proposed by the offeror will be multiplied by the Government-provided estimated quantity of prescriptions and Government-provided Average Wholesale Price (AWP)(of brand name and generic drugs) to determine a "Total Expected Government Cost for Reimbursement of Network Retail Pharmacy Costs," which will be used for evaluation purposes. The Government will use the estimated quantities of prescriptions for each option period as listed in Section B of the solicitation. The "Total Expected Government Cost for Reimbursement of Network Retail Pharmacy Costs" will be the summation of pharmacy costs as calculated in Table L-1, for all five option periods." As long as contractors meet the proposed guaranteed average discount percentages in Table L-1; are there any Government imposed restrictions or requirements on the negotiated discount rates, MAC, pricing

methodology, financial arrangements, etc…between the contractor and the pharmacy providers? Please confirm contractors will negotiate and contract the network reimbursement rates directly with the pharmacy providers. Please confirm contractors will be allowed to utilize their proprietary MAC to price claims.

Response 55. Network pharmacy agreements are the sole responsibility of the contractor. Section C.6.3. specifies the only restrictions relative to the network agreements.

Question 56. It would appear that the solicitation for the TRICARE Retail Pharmacy (TRRx) Program would be an excellent opportunity to apply the Government's commercial item acquisition procedures under FAR Part 12. The solicitation contemplates a service that is clearly of a type customarily used by the general public or non-governmental entities for purposes other than governmental purposes (i.e., commercial item). In fact, the solicitation requires the contractor to provide TRICARE beneficiaries the same level of services provided to beneficiaries of other commercial clients to the extent allowed by Federal regulation and TRICARE policy (SOW C.6.1). Using FAR Part 12 might expand TMA's competition base to induce companies that would not otherwise do business with the Government to tender offers. Any special requirements of the TRRx Program, such as incentives and reports, could still be accommodated under FAR Part 12 via the tailoring process at FAR 12.302 based on customary commercial practice. Recommend that the issue should be referred to the agency's commercial item advocate for guidance.

Response 56. The Government has attempted to keep this acquisition as close to commercial practices as possible. However, due to requirements unique to this solicitation, use of FAR Part 12 is not practical. Use of FAR Part 12 was considered during development of the Acquisition Plan as approved by the Director, Defense Procurement.

Question 57. The solicitation includes the "Cost Accounting Standards" clause (FAR 52.230-2) at Section I.58 and "Administration of Cost Accounting Standards" clause (FAR 52.230-6) at Section I.59. It should be noted that, by law and the Cost Accounting Standards (CAS) Board's implementing rules, the ensuing contract would be expressly exempted from CAS. Specifically, the exemption at 48 CFR 9903.201-1(b)(15) states that CAS is not applicable to firm-fixed price contracts or subcontracts awarded on the basis of adequate price competition without the submission of cost or pricing data. This exemption was created under Section 802, "Streamlined Applicability of Cost Accounting Standards," of the National Defense Authorization Act for Fiscal Year 2000 (Public Law 106-65). The underlying rationale for the exemption, which was supported by the Director of Defense Procurement in the Office of the Under Secretary of Defense for Acquisition and Technology, was that in such circumstances, it is very difficult to justify the additional cost and administrative burden. That is, when neither the price nor any payment provision of the contract will be based on actual costs incurred by the contractor to perform the work, there would be no benefit to the Government from imposing CAS. Inasmuch as the TRRx contract will be fixed-price, awarded with adequate price competition, and not involve the submission of cost or pricing data, the CAS clauses should be removed. Moreover, the contracting officer does not have the discretion to impose a requirement that has been otherwise exempted by law (see Comptroller General Decision No. B-184333 (1976) involving the Gulf Oil Trading Company). Recommend that the issue be referred to the Director of Defense Procurement for guidance.

Response 57. The contractual vehicle is not firm-fixed-price in accordance with FAR 16.202. This is a requirements contract in accordance with FAR 16.503. Additionally, the incentive provision of this solicitation for maintaining the guaranteed minimum discount and dispensing fee also precludes the contract from being firm-fixed-price.

Question 58. RFP Reference Section C.1.4.states "The contractor shall use the Pharmacy Data Transaction Service (PDTS) to verify eligibility, search for Other Health Insurance (OHI) information, and check and update the Central Deductible and Catastrophic Cap (CDCF) file. PDTS also supports Drug Utilization Review and adverse drug interaction screenings." (a) Is this access to PDTS real time on line? (b) Can other information, such as beneficiary pharmacy claims history be viewed? (c) We understand the current MCS contractors have access via "SelectRX". Is this the same availability under TRRx? If so, can the government provide some further documentation on this system?

Response 58. (a) Yes.

(b) Beneficiary claims history may be viewed via SelectRx.

(c) Yes, access will be via SelectRx. Following award, the Government will work with the successful offeror to establish connectivity.

Question 59. RFP Reference Section C.8.7. requires the contractor to coordinate with the MCS to ensure availability of DD 2642 claim forms at TSCs and to make this form available to beneficiaries on line via their website. (a) Will the MCS contractors provide the Retail Pharmacy contractor with the electronic version of the form to be loaded to the website? (b) Is the current DD 2642 a single or multi-part carbonless form? (c) If multi-part, how will an electronic form accommodate a need for multi-copy submission?

Response 59. (a) The form will be available in a downloadable version from the TMA website. The contractor may establish a link from its website to the form.

(b) The form is a single page form, with directions on the back.

(c) Not applicable.

Question 60. RFP Reference Section C.11. This section states "The contractor shall submit all Prior Authorization approvals and denials into PDTS as described in the TRRx PDTS Interface Control Document (ICD) at Attachment 4, Section J. The contractor shall complete reconsiderations of initial determinations and complete appeals in accordance with the requirements at C.16.3.4 "Appeals Plan". Is the submission of the authorization or denial real time on line into PDTS, or is the submission made through a batch process?

Response 60. The submission is in real time.

Question 61. RFP Reference Section G.1.2.5.2. – G.1.2.5.4., and G.1.2.5.6. These sections provide the performance standards for the TRRx and PDTS to meet regarding TED accuracy and timeliness. (a) Will the government calculate and report these rates for the contractor and PDTS separately or in the aggregate? (b) If the latter, how is the determination made as to whether the contractor has fulfilled their obligations under these requirements as outlined in Section G.?

Response 61. (a) The report will complete the calculations in the aggregate, pending determination of the error source upon return to PDTS.

(b) The contractor is required to correct any contractor caused errors in the specified time frames starting at the time notification is received from PDTS.

Question 62. RFP Reference Section G.1.2.5.5 and G.1.2.5.7. These sections provide the performance standards for TED Vouchers. Section G.1.2.1. states the TED Voucher will be submitted to TMA by PDTS. Wouldn't then the two standards presented in the referenced sections apply to PDTS rather than the TRRx?

Response 62. Correct. Unless the contractor submits invalid data. These standards are for overall program surveillance purposes.

Question 63. L.9.2 of the RFP requires both the offeror and its first tier subcontractors to submit past performance data from each of the five largest current customers to whom they provide PBM services. L.9.2 further states that the offeror is not to include accounts from its own subsidiaries, subcontractors or team members. If the situation exists where the offeror is one of the first tier subcontractor five largest accounts, may the first tier subcontractor include the offeror as one of the five entities filling out a 19-L?

Response 63. No. This omission will be addressed in an upcoming amendment.

Question 64. Please confirm if TMOP is using TEDS through PDTS. If not, when do they expect it to be operational?

Response 64. TMOP is not currently submitting TEDS through PDTS. TEDs will be submitted through PDTS in the near future.

Question 65. Which Evaluation Factor(3or4)is to be discussed in the Oral Presentation? L.7.3 through L.7.3.4 indicates that Factor 3 is in the Written proposal. L.8.5.6.2 indicates that Factor 3 is in the oral presentation.

Response 65. Factor 4 is to be covered in the oral presentation. This will be corrected in an upcoming amendment.

Question 66. When is the ICN assigned by PDTS?

Response 66. At the time the TED record is prepared for submission to TMA.

Question 67. At how many physical locations will the government require access to our claims data?

Response 67. No more than two, the PDTS Customer Service Center in San Antonio, Texas, and TMA at Aurora, Colorado.

Question 68. Will the implementation of the TRRx contract coincide with the TNEX transition schedule?

Response 68. No. TRRx will be implemented nationally 180 calendar days after award.

Question 69. The contractor shall provide beneficiary service to non-English speaking and hearing impaired beneficiaries. Which non-English speaking languages need to be provided?

Response 69. The contractor shall make provision to accommodate any beneficiary who calls.

Question 70. Can Section C.14.6.3 be changed to IATO in 30 days? With ATO at a later date, say 12 months?

Response 70. No. Section C.14.6.3. specifies that the contractor will provide the necessary documentation to begin the DITSCAP process within 30 calendar days of award. The Government expects the contractor to attain the ATO by the start work date of the contract.

Question 71. Is PDTS currently producing all TEDs for TMOP? If not now, when?

Response 71. TMOP is not currently submitting TEDS through PDTS. TEDs will be submitted through PDTS in the near future.

Question 72. Medical Necessity determination shall be completed by physicians, pharmacists, registered nurses or physician assistants. Please confirm that this requirement is referring to the completion of forms requesting medical necessity and that they are to be completed by these specified professionals. This sentence could also be understood to mean that the review and determination of approval for medical necessity exceptions may only be performed by these professionals on the PBM vendors staff.

Response 72. Your second interpretation is correct. The review and determination of approval for medical necessity exceptions may only be performed by these professionals on the PBM vendor's staff.

Question 73. Please explain in greater detail the difference between Medical Necessity and Prior Authorization.

Response 73. Prior authorization criteria are established by the DoD P&T Committee and can be viewed at www.pec.ha.osd.mil . The criteria are condition based and require written authorization from a provider in order for the drug to be dispensed. Medical necessity is a process under the Uniform Formulary, used in most cases, to authorize the dispensing of a nonformulary drug at the formulary co-pay. Certain other limited circumstances also apply as defined by the Uniform Formulary rule.

Question 74. Please define the current Rx prior authorization and medical necessity procedures performed by the current MSCS regions and by the PDTS subcontractor. How does that compare to the new requirements?

Response 74. The current processes are not applicable to this solicitation. The requirements under this solicitation will be governed by the Uniform Formulary Final Rule. The current proposed rule is available through the Federal Register.

Question 75. Section G.2. seems unclear on payments for Administrative Fees. If one TED in a batch does not pass edits will the entire batch payment be withheld until the single TED is corrected or will payment be made for the TEDs in the batch which do pass the edits?

Response 75. No. Payment will be made for all TEDs passing edits. Those failing the edit process will be returned to PDTS for correction, either by PDTS or the contractor.

Question 76. How is the Negative Incentive described in H.2.3. calculated? Is it the same as the Positive Incentive in H.2.2. which is calculated at 5% of the difference between the actual cost and Government calculated cost with a cap set for each option year? Or is it dollar for dollar with no cap?

Response 76. The negative incentive is dollar for dollar with no cap.

Question 77. With respect to the contractor requirements relative to DITSCAP and the IS/Networks Certification & Accreditation process ("the C&A Process") please confirm that the contractor will not be required to directly electronically interface with any Defense Information System including DEERS, and that such direct interface is to be accomplished by other DITSCAP certified contractors such as PDTS.

Response 77. Confirmed.

Question 78. With respect to the process of obtaining the Approval To Operate (ATO), the process specified by TMA at C.14.6.3 infers that the contractor shall initiate the process for IS/Networks Certification & Accreditation ("the C&A Process") after the award. Is the process envisioned by TMA a process by which the contractor shall, after the process, be considered completely DITSCAP certified, or a process by which the contractor is assessed to meet the minimum standards necessary to interface with another system, PDTS in this case, that must itself maintain DITSCAP certification?

Response 78. The Government's preference is that the contractor have the ATO at the end of the phase-in period and to that end, will work with the contractor following award to obtain the Approval to Operate prior to delivery of pharmacy services.

Question 79. Section B. Paper Claims. Paper claims are a separate CLIN in the RFP. From the perspective of TMA please provide us the origin of these paper claims in descending order by source. Can TMA shed any insights into how these figures were arrived at?

Response 79. Paper claims will be received from beneficiaries utilizing non-network pharmacies and from beneficiaries submitting claims for OHI. Quantity estimates were derived from historical experience from fourth quarter of CY 2002.

Question 80. Section C.11. With respect to cases of Prior-Authorization and Medical Necessity, in commercial practices Point of Sale pharmacy transactions are often stopped and returned to the pharmacy with an appropriate NCPDP reject code. Is the operational vision to have PDTS be the only place that NDC's are flagged, or does TMA anticipate adopting the commercial best practice and allow the contractor to flag such claims in responses to pharmacies?

Response 80. The flag will reside at PDTS since prior authorizations will be portable across points of service and PDTS is the only place where all dispensing data reside.

Question 81. What post processing activity will PDTS perform prior to submission of TEDs?

Response 81. PDTS processes claim information from the Contractor and matches it with demographic information received from DEERS. PDTS will reject a claim back to the Contractor if the required fields for TED are not populated or do not pass the on-line editing process. The required fields are noted in the TRRx ICD.

Question 82. Section G. It is our understanding that the Government desires to adopt commercial best practices to the maximum extent possible. Under standard commercial practices when member eligibility and other plan information is verified, the prescription is approved for payment and the Pharmacy Benefit Manager incurs an obligation to pay the pharmacy. Is it possible that any post processing activities performed by PDTS during the ten-day period following submission of claim information to PDTS by the contractor results in a denial of a previously approved claim?

Response 82. PDTS does not take 10 days to process TEDs. The 10 day hold is to account for the vast majority of reversals and/or non-compliant patient return to stock drugs by the retail pharmacy. There is always a possibility that a previously approved claim could be denied during the TED payment process.

Question 83. Section C.8.2. In keeping with the government's desire to adopt best commercial practices, please address the following. The time period extended to network pharmacies by pharmacy benefit managers to reverse previously submitted and approved claims is not limited to a ten-day period; the limit envisioned under TRRx. This is not in the best financial interest of the government; a narrow ten-day window limits the opportunity for pharmacies to reverse claims. And, is inconsistent with pharmacy practice. Broader reversal windows will assist pharmacy compliance with return to stock reversals. Narrow windows, such as the one proposed, hinder compliance. TMA could expect significant service issues if a narrow reversal window is imposed; leading to increased administrative costs. Would TMA reconsider this limitation and adopt contractor's standard practices regarding reversal policies?

Response 83. There is not a ten day limit on reversals. There is a ten day hold period to facilitate the majority of reversals. Reversal can be processed at anytime in accordance with the Contractor's network agreements with the retail pharmacy. The ten day hold was established to limit the overall number of corrected TEDs that would result by the TEDs being processed automatically from a paid claims transaction.

Question 84. Please explain the process by which the contractor, working on behalf of TMA, would handle a claim that a pharmacy desires to reverse beyond the proposed ten-day window.

Response 84. Reversals beyond the 10 day hold period would be processed exactly like those within the 10 day hold period. A reversal beyond the 10 day hold period would produce a corrected TED and would result in a withhold of that amount from a future payment to the retail pharmacy.

Question 85. Section G. Under commercial best practices, PBM's pay network pharmacies according to specified cycles, and each cycle payment is a consolidated payment for all claims payable to a pharmacy (or a chain of pharmacies) for all plans that contract with the PBM for services. In keeping with the desires of network pharmacies, this is a single lump-sum payment accompanied by appropriately detailed remittance advices. This practice does not preclude the PBM from detailing expenditures by pharmacy to plan sponsors; it simply reduces the mutual accounting and administrative costs of network pharmacies and PBM's. Adopting practices that are inconsistent with industry best practice will add administrative costs to the government, and decrease satisfaction among network pharmacies. Recognizing the government's interest in minimizing administrative costs, can the contractor assume that it can reimburse its network pharmacies under existing practices if it maintains the ability for TMA to accurately assess program expenditures, in detail, by pharmacy, by drug, by member, etc?

Response 85. Payments to pharmacies using the Government accounts cannot be commingled with other payments to pharmacies.

Question 86. Upon what specific action by the contractor does PDTS and TMA undertake the creation of TEDs? Are TED records created by PDTS from the POS claim transaction itself, or are they created from batch records sent from the contractor to PDTS on an agreed upon schedule (e.g. daily, twice monthly, etc.)? Or, a combination of both?

Response 86. The record is created at the time of the transaction. Necessary demographic data to complete the record are provided in a nightly batch file from the Defense Manpower Data Center to PDTS.

Question 87. Page 1, Item 9 and Page 49, Item L.6.2. With respect to proposal submission requirements, please clarify. There appears to be some discrepancies between requirements specified regarding the number of hard copy and electronic copies, as outlined in pages 1 and 49. Please specify the number of hard copy and the number of electronic copies required.

Response 87. The instructions in Section L are correct. Section A, Block 9 will be corrected to read Original plus 2 copies.

Question 88. Section I.26 of the solicitation includes clause 52.215-10 Price Reductions for Defective Cost or Pricing Data. FAR part 15.408 (b) states that this clause should only be included "… in solicitations and contracts when it is contemplated that cost or pricing data will be required from the contractor or any subcontractor." Solicitation section L.10.1. states "Cost or pricing data are not required to be submitted." Therefore, we suggest that I.26 is inconsistent with the specifications of this solicitation and should therefore be removed from the solicitation. Will TMA amend the solicitation by deleting this requirement?

Response 88. It is anticipated that cost or pricing data will not be required, and, in accordance with Section L.10.1, it is not required or to be submitted. The clause, however, will not be deleted.

Question 89. Section L.10.1. indicates that "… information 'other than cost or pricing data' is required in accordance with FAR 15.403-3 to assist in the determination of a fair and reasonable price offered. Any submitted information "other than cost or pricing data" may be in the offeror's own format, with the exception of the Network Reimbursement Table, L-1." FAR 15.403-3(b) states "When adequate price competition exists (see 15.403-1(c)(1)), generally no additional information is necessary to determine the reasonableness of the price. However, if there are unusual circumstances where it is necessary to determine the reasonableness of price the contracting officer shall, to the maximum extent practicable, obtain the additional information from sources other than the offeror. In addition, the contracting officer may request information to determine the cost realism of competing offers or to evaluate competing approaches." Section L does not require any information related to cost realism. Furthermore, the only other cost information that is requested is Table L-1 and "… a narrative or quantitative explanation as any differences in the proposed unit prices between the Medicare Dual-Eligible and TRICARE-Only Eligible sub-CLINs." Given the above, is it correct that the only information that should be submitted in the cost proposal is the completed section B, Table L-1 and the aforementioned Narrative if applicable?

Response 89. Yes, the only cost information to be submitted with the offeror's proposal is the completed Section B, Table L-1 and any differences in proposed unit prices for Medicare Dual-Eligible and TRICARE-only Eligibles. If, however, the contracting officer determines additional data is required in determining a fair and reasonable price, such data may be requested.

Question 90. Section I.58 and I.59 incorporate by reference FAR 52.230-2 Cost Accounting Standards and 52.230-6 Administration of Cost Accounting Standards. In addition, K.13 incorporates 52.230-1 Cost Accounting Standards Notices and Certifications. The solicitation requirements make it clear that the government is seeking commercial PBM services to take advantage of the commercial best practices and significantly reduce its current claims processing costs related to pharmacy claims. The government has elected to achieve this through a firm-fixed -price competitively bid requirements contract with certain firm-fixed-price lump sum CLINs for transition activities. FAR part 16.201-1 states " A firm-fixed-price contract provides for a price that is not subject to any adjustment on the basis of the contractor's cost experience in performing the contract. This contract type places upon the contractor maximum risk and full responsibility for all costs and resulting profit and loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties." CAS 9903.201-1 CAS Applicability defines two separate exemptions that would exempt this contract from the aforementioned CAS requirements. 9903.201-1 (b) states that "the following categories of contracts and subcontracts are exempt from all CAS requirements: … (6) Firm fixed-priced … contracts and subcontracts for the acquisition of commercial items. … (15) Firm-fixed-price contracts and subcontracts awarded without the submission of any cost data." GSA, DoD and other government agencies award fixed price requirements contracts of this nature without the inclusion of Cost Accounting Standards in almost all circumstances. The contractor will incur significant administrative costs if these requirements were included in this solicitation. Furthermore, since the bidders for this contract will be commercial entities that do not perform CAS covered contracts, the CAS would require all of this administrative cost to be allocated to this contract to comply

with the causal and beneficial allocation requirements of CAS 418. Finally, unlike the MCS contracts, this contract does not include a cost reimbursable health care cost under the contract CLINs. The pharmacy spend is paid directly by the government and any measurement of the costs for purposes of determining the incentive payments under this contract will be done by PDTS (see H.2.4. which states in part "PDTS will accumulate reimbursement data from all retail network pharmacy transactions. PDTS will be the sole determining source for calculating the payment of an incentive or the assessment of a negative incentive.") Based on the above, it is apparent that the aforementioned CAS provisions of this solicitation are non-applicable. Will TMA amend the solicitation by deleting this requirement?

Response 90. No. The CAS requirement will not be deleted. Please see Response 56 above.

Question 91. Section H.2. discusses the Financial Incentives for Actual Network Reimbursement Costs and also outlines a negative incentive associated with Actual Network spend. H.2.2. provides for a sharing of savings of 5% to the contractor and 95% to the government up to a nominal cap of $1.5 to $2.5 million depending upon the year. Section H.2.3. creates a reverse negative incentive which is shared 100% by the contractor and 0% by the government with no cap other than the total amounts paid to the contractor for all administrative services under this contract. Please respond to the following questions. (a) A 5% gain sharing with a nominal cap will not achieve the governments objective of achieving a 5 year partnership with a pharmacy benefits manager that is continuously developing new methods of saving for the employer group (in this case the government) related to their pharmacy spend. The development and implementation of these future programs will require the expenditure of significant administrative and technology dollars to achieve the maximum possible savings for the government in the out years of this contract. The minimum industry standard to create an incentive that adequately compensates for these costs and the development of new best practices is a 50/50 sharing with no cap. Would the government consider modifying the incentive structure to allow for the development of future approaches to maximize the pharmacy spend savings under this contract for the full 5-year term of the contract? (b) The inconsistency between the gain sharing provisions of 5%/95% versus the loss sharing provisions of 100%/0% may force the bidders to be overly conservative when bidding the Guaranteed Average Discount Percentage and Guaranteed Average Dispensing Fee. In past for MCS contracts and other similar programs, the gain and loss sharing provisions are mutual and parallel. Would the government consider modifying H.2.3. to make it parallel with the structure under H.2.2.? (c) Currently, there is significant pressure by various governmental and commercial payers to eliminate or significantly restructure the process to establish AWP by the pharmaceutical manufacturers. This pressure is being asserted by Congress, state legislatures, Department of Justice and various Assistant U.S. Attorneys, State Attorneys General, commercial health plans and employee and employer groups (through Class Action Suits). The current difference between AWP and actual acquisition cost is what permits the pharmacies to provide a discount off AWP. The forces discussed above may change the structure of AWP over the 5-year term of the contract. If AWP was partially or fully restructured, the negative incentive structure currently included in H.2.3 could create negative incentives of $10's of millions of dollars per year for the contractor at the same time as the government's actual drug spend is lower. Would the government consider adding language to indicate that section H.2. will be renegotiated if the basic structure of AWP changes?

Response 91. (a) No.

(b) No.

(c) No additional language is necessary. If such changes occur, they will be directed through the Changes Clause of the contract and the contractor may submit a proposal to address the cost impact.

Question 92. C.8.1 states "Pharmaceutical claims received for pharmaceuticals and supplies furnished in other locations shall be forwarded to the TRICARE contractor responsible for processing claims for those locations." Would these claims be forwarded to MCSC processing OCONUS claims?

Response 92. Yes, or if applicable, to the TRICARE Global Remote Overseas Healthcare contractor.

Question 93. C.8.1 states "The demographic data from DEERS necessary to determine the appropriate bank account will be provided to the contractor two calendar days before PDTS submits the TRICARE Encounter Data (TED) record to TMA. The contractor shall match the DEERS data to the claim records, and provide the account data back to PDTS to be included in the TED record within one calendar day of receipt of the demographic data."

How will this demographic data be communicated back to the TRRx contractor? How is the TRRx contractor to communicate back to PDTS the account data? Please provide needed data elements and file layout. Why is this separate transaction needed? Couldn't this information be passed as information in the original transaction from PDTS?

Response 93. Data transactions between the contractor and PDTS are in accordance with the PDTS Interface Control Document, Section J, Attachment 4. Section C.8.1. will be amended to revise this requirement so that the contractor will not have to receive the demographic download or retransmit demographic data.

Question 94. C.8.2 states "Claims for prescriptions filled but not dispensed (noncompliant) shall be reversed within ten calendar days of the date the original claim was submitted." (a) What happens to reversals after 10 calendar days? Currently we allow reversals up to 60 days after claim submission. (b) If an original claim is reversed within 10 days, is a TED record written for that transaction?

Response 94. (a) Reversals beyond the 10 day hold period would be processed exactly like those within the 10 day hold period. A reversal beyond the 10 day hold period would produce a corrected TED and as a result a withhold of that amount from a future payment to the retail pharmacy.

(b) No.

Question 95. C.8.4 states "In addition to Government data requirements specified herein, in Section F, and in Section J, the contractor shall provide the Government read-only access to its claims system to facilitate Government beneficiary service support." (a) We assume that inquiry transaction into claims system by ID/password would be sufficient, please clarify. (b) Should security for these ids be at the global level or by a regional breakout. What will be the location for these IDs and how many IDs are needed?

Response 95. (a) Yes, that is sufficient.

(b) Security should be at a global level. The access will be used by the PDTS Customer Service Support Center in San Antonio Texas, and by TMA in Aurora, Colorado. DoD will require at least 6 but no more than 15 IDs to cover the 7x24 operations of the CSSC and TMA surveillance.

Question 96. C.8.8.1 and C.8.8.2 state "99% of electronic claims shall be processed to completion within five seconds of receipt, measured on a monthly basis. This processing time is exclusive of the time the transaction is being processed at PDTS. 100% of electronic claims shall be processed to completion within five working days of receipt, measured on a monthly basis." Do these standards apply to the POS electronic transactions only? Because the majority of POS transactions will be completed in 5 seconds, it is unclear why 5 days are needed for 100% claims. Please explain.

Response 96. Yes, the standard applies only to POS electronic transactions. The five days for the balance is allowed for completing prescriptions requiring clarification or intervention, e.g., prior authorization or medical necessity determination.

Question 97. C.11. states "The contractor shall submit all Prior Authorization approvals and denials into PDTS as described in the TRRx PDTS Interface Control Document (ICD) at Attachment 4, Section J." Note: The ICD document describes how to override an authorization in the section describing prior authorizations. However, the ICD document does not describe how prior auth transactions for approvals and denials will be submitted to PDTS. Will these be via transaction files or data entry screen? How will this information be translated into a TED record? Please explain.

Response 97. Prior authorizations are entered into PDTS by data entry screens associated with SelectRx or by the use of outcome/intervention codes during the on-line submission of a claim. Since prior authorizations are portable, the submission of a claim and the receipt of a denial is the Contractor's indication that a PA must be performed by the Contractor. Once a PA is completed, PDTS will produce a TED for payment as a result of the paid claims transaction.

Question 98. C.12.2 states "The contractor shall submit all Medical Necessity Determination approvals and denials into PDTS as described in the PDTS ICD at Attachment 4, Section J." The ICD document does not describe how to submit medical necessity determinations approvals and denials into PDTS. Will these be via transaction files or data entry screen? How will this information be translated into a TED record? Please explain.

Response 98. Medical necessity determinations are entered into PDTS by data entry screens associated with SelectRx and by the use of outcome/intervention codes during the on-line submission of a claim. Since medical necessity determinations are portable, the submission of a claim and the receipt of a denial is the Contractor's indication that a medical necessity determination must be performed by the Contractor. Once a medical necessity determination is completed, PDTS will produce a TED for payment as a result of the paid claims transaction.

Question 99. C.14.3 states "Errors in the transmission of TED records between PDTS and TMA will be corrected by PDTS." How will these corrections be communicated to the contractor? How will this process be monitored between all parties (TMA, PDTS, TRRx contractor)?

Response 99. Errors in transmission will be automatically corrected by PDTS. PDTS will notify the contractor of any problems affecting the contractor's payment schedule.

Question 100. C.21 describes contract phase out. Who funds contract phase-out for out-going contractor?

Response 100. Phase-out costs for the contract resulting from this solicitation are included in CLINs 1007, 2007, 3007, 4007, and 5007.